



KENTUCKY HEALTH BENEFIT EXCHANGE
HEALTH INSURANCE
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**Escalation
of Issues**



Escalations

This training will address the options for resolving issues and problems with healthcare enrollments, applications and special circumstances with HealthCare.gov or through state based pathways.

Escalations

Acronyms/Terms

APTC	Advance Premium Tax Credit
Casework	Activity to resolve problems, issues, or changes on an application or enrollment
CMS	Centers for Medicare and Medicaid Services
CSR	Cost Sharing Reduction
DCBS	Department of Community Based Services
DMI	Data Matching Issue
DOI	Department of Insurance
FFM	Federally Facilitated Marketplace
HICS	Health Insurance Caseworker System
KCHIP	Kentucky Children's Health Insurance Program
KHBE	Kentucky Health Benefit Exchange
QHP	Qualified Health Plan
RO	Regional Office
SEP	Special Enrollment Period

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Case Issues

There may be issues that you are not able to resolve on your own as an Assister.

Case issues often require investigation to determine the cause and then steps to ensure the correct resolution path is taken.

In many cases, that research has to be conducted by individuals with different system access or area of expertise.

It is important to understand what issues must be resolved at the state level and what issues are resolved by the federal health insurance marketplace. Ensuring the correct actions are taken can expedite resolution.

Example case issues:

- Issuer has no record of enrollment
- APTC not applied to premium
- Assister not associated with a case

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State and Federal Resources

State

Medicaid/KCHIP cases should be resolved with state agencies.

- Kentucky Health Benefit Exchange
1-855-326-4650
- Benefind/DCBS 1-855-306-8959
- Department of Insurance 1-800-595-6053

Federal

Most QHP issues can be resolved directly with the issuer.

Report issues with qualified health plans to the federal health insurance marketplace call center.

They will work with you to determine the best resolution path based on the situation.

FFM Call Center: 1-800-318-2596

Assister Line #: 1-855-868-4678

CAC Line #: 1-855-879-2683

KY Passcode: 502-999-9999

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State Issues

Kentucky Health Benefit Exchange

Support Professionals Line

1-855-326-4650

Tax Line

1-844-373-2417

KHBE.kynect@ky.gov

- 2016 Form 1095 A and B
- Medicaid/KCHIP application or enrollment
- Support Professionals line
- Assister program or training issues
- State specific policy questions

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State Issues

benefind/DCBS
1-855-306-8959

- Case is locked in benefind system and changes cannot be reported.
- Consumers case has not transferred from FFM to benefind.
- Income calculation error

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State Issues

Certain appeals

Families and Children Administrative Hearings Branch
105 Sea Hero Road Suite 2
Frankfort, KY 40601
Phone: (502) 564-3140
Fax: (502) 573-1014

The state of Kentucky is an assessment state on the FFM. This means the FFM assesses eligibility for MAGI-related Medicaid and CHIP. The state Medicaid agency makes the final eligibility *determination* and aggrieved consumers may appeal through the state process.

Non-MAGI-Related Appeals. The FFM does not render eligibility determinations for non-MAGI-related Medicaid. If a state Medicaid agency denies non-MAGI Medicaid, aggrieved consumers may appeal through the state's Fair Hearing process.

The CHFS Families and Children Administrative Hearings Branch schedules administrative hearings conducted by hearing officers in many diverse programs and services provided participants by CHFS such as Medicaid including initial and ongoing eligibility for medical benefits, eligibility as a permanent and totally disabled individual and monthly personal obligation for cost of nursing facility care

Also see our Appeals webinar on our Agent and Assister Webinars site page: <http://healthbenefitexchange.ky.gov/Pages/Agentandkynectorwebinars.aspx>

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State Issues

Complaint or Appeal help

Kentucky Department of Insurance
Consumer Protection Division
1-800-595-6053 (Kentucky residents only)
or
1-502-564-6034
P.O. Box 517
Frankfort, KY 40602
http://insurance.ky.gov/Home.aspx?Div_ID=4

Office of the Ombudsman

(502) 564-5497
Toll-Free 1-800-372-2973

TTY (for hearing impaired) 1-800-627-4702

Complaints

- If a consumer needs help with an appeal or have a complaint about an issuer, they may contact the **Department of Insurance (DOI)** for assistance. Ask to speak to a consumer complaint investigator.
- The **Office of the Ombudsman** answers questions about CHFS programs, investigates customer complaints and works with CHFS management to resolve them, advises CHFS management about patterns of complaints and recommends corrective action when appropriate

Also see our Appeals webinar on our Agent and Assister Webinars site page: <http://healthbenefitexchange.ky.gov/Pages/Agentandkynectorwebinars.aspx>

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FFM Issues

Assisters may contact the following help desks as needed:

For general questions about **FFM registration, CMS policies, and other assister issues**, please contact:
FFMProducer-AssisterHelpDesk@cms.hhs.gov

For questions about logging into the **CMS Enterprise Portal**, please contact: CMS_FEPS@cms.hhs.gov
or 1-855-CMS-1515

For questions about the **MLMS (Marketplace Learning Management System)** please contact:
MLMSHelpDesk@cms.hhs.gov

- Accessing CMS training sites/resources
- Federal policy questions

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FFM Issues

FFM Call Center
1-800-318-2596

FFM Navigator Marketplace Call
Center line
1-855-868-4678
Enter your Assister code:
502 999 9999

CAC Marketplace Call Center line:
1-855-879-2683
Enter your Assister code:
502 999 9999

All QHP issues or questions should be directed to either the FFM Call Center or the Assister line for your role.

These issues may include:

- Special Enrollment Periods
- Data Matching Issues such as proof of citizenship or verification of income.
- Appeals
- Urgent Medical Situation
- Health Insurance Caseworker System (HICS)



HICS

Health Insurance Caseworker System

Escalations

HICS : Health Insurance Caseworker System

The Health Insurance Casework System (HICS) is the official tracking system for Marketplace casework.

Assisters **do not** initiate HICS escalations, but it is important to understand the process as you advise and assist consumers with their issues.

- HICS is a web application that QHP issuers are required to use.
- HICS is used by multiple parties.
- HICS is used for casework intake and casework resolution activities.

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HICS : Health Insurance Caseworker System

HICS issues may include, but are not limited to, the following:

- Enrollment and Termination Requests
- Reinstatement Requests
- Access to Services/Benefits
- Premium or Premium Payment Disputes and Refunds
- Retro Enrollment/Retro Termination Requests
- Cancellation/Termination Requests
- Proper Application of the APTC and CSRs
- Effectuation of Appeal Decisions
- Delayed Enrollment Processing
- Missing Enrollments
- Plan Benefit Issues

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HICS: Health Insurance Caseworker System

When cases are recorded in Health Insurance Casework System (HICS) they are assigned to the appropriate group for review.

This may be:

- CMS
- CMS contractor
- Issuer

Most cases are assigned to issuers

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HICS: Health Insurance Caseworker System

CMS Casework Responsibilities

- **Approving/denying exceptional circumstance special enrollment periods (SEPs)**
- **Monitoring issuer cases**
 - Provide technical assistance and help issuers with their cases
 - Review issuer casework volume, age of cases, and trends

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HICS: Health Insurance Caseworker System

CMS Casework Responsibilities

- **Consumers may receive follow-up telephone calls to learn more about their case.**
Assisters can prepare their clients with information that lists the necessary information, an explanation of the issue, and the desired outcome.
- **Reassure clients that they may or may not receive a call.**
If a consumer doesn't receive a call, it doesn't mean that the case is not being reviewed.
- **Call center can provide status of HICS.**
- **Resolution times may vary depending on the nature of the issue, current volume, and urgency. Standard cases are resolved within 15 calendar days of receipt by issuer.**
- **Urgent medical need cases are expedited for resolution within 72 hours of receipt by issuer.**

Escalations

HICS : Health Insurance Caseworker System

QHP issuers operating in the FFM or a SBM-FP must investigate and resolve, as appropriate, consumer cases.

HICS is used to direct an issuer to:

- Make changes to enrollment effective and end dates.
- Change Advanced Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSRs) as a result of appeal decision.
- Other corrections.

Escalations

HICS : Health Insurance Caseworker System

Issuer Responsibilities

Plan and concerns with issuer are the primary responsibility of the issuers to research and resolve.

Issuers may receive direct instruction from CMS on steps to resolve a case.

If there are cases that the issuer is not able to resolve, the issuer can reach out to a CMS Caseworker or Account Manager for technical assistance.

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HICS: Health Insurance Caseworker System

HealthCare.gov call center escalates reported issues using the HICS system.

There are specific categories for performing a HICS escalation.

CSRs cannot perform a HICS for reasons outside the issues that fit specific criteria.

The CSR will first review the case to determine if there is another reason for the issue.

Example escalations:

- Enrollment or effective date error.
- The consumer reports a discrepancy in premium amount .
- The consumer has experienced an exceptional circumstance, misinformation or misrepresentation.
- Consumer's coverage was terminated in error.

Escalations

HICS: Health Insurance Caseworker System

HICS is not an enrollment system. Consumer must have an enrollment before action can be taken concerning effective dates via the HICS system.

Casework is the “last resort”

Consumers/assisters should work through available resources, including their issuer when applicable, before looking to the casework process as a solution.

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HICS: Health Insurance Caseworker System

Marketplace Call Center

- When contacting the Marketplace Call Center with enrollment issues, gather as much information about the application as possible. Consumers should have their application ID available when they call.
- If the consumer's situation does not fit into a HICS category for resolution, the FFM call center representative can assist you in determining a solution or may have an escalation path they can utilize for the specific issue.
- FFM Call center may provide an update on the HICS status.

Escalations

HICS: Health Insurance Caseworker System

Tips for Assisters

- Encourage consumers to work closely with their issuer to resolve problems before turning to the Marketplace Call Center.
- Help consumers review and understand Marketplace notices.
- Help consumers give the Marketplace Call Center as much information as possible.
- Tell consumer they may receive calls from caseworkers and appeals workers.
- Make sure consumers understand and are aware of the issue and desired resolution.
- Consumer may receive an auto dialer call with a message to contact the marketplace. Makes sure consumers make the return call when/if they receive a call.
- Assister should help triage consumer cases to determine if the reason for an issue can be explained with policy.



Examples of HICS and sample resolution language

In this section we will review some examples of HICS escalation and the resolution notes in the HICS system.

Escalations

HICS : Health Insurance Caseworker System

After a HICS has been entered into the system by a call center representative, the appropriate party investigates and responds. This may be the issuer, CMS caseworker or subcontracted caseworker.

We will review several examples of HICS that have been submitted and the resolution notes entered by the issuer.

HICS categories may be changed, removed or added.

Escalations

HICS : Health Insurance Caseworker System

Reinstatement Requests

The consumer believes their coverage was inappropriately terminated or canceled by the Issuer, through an Issuer error or Marketplace error.

HICS Summary after Issuer investigation

Issuer terminated the consumer on [Date] for failure to pay premiums. Upon review, it appears a payment was not appropriately applied within the applicable grace period to the consumer's account. As a result, we have reinstated the consumer due to Issuer error. Consumer was satisfied and had no other issues to report. A resolution letter will be mailed to the subscriber on [Date].

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HICS : Health Insurance Caseworker System

Premium Disagreement

Premium disagreement cases may be caused by a number of different scenarios.

HICS Summary after Issuer investigation

A review of Marketplace files shows the consumer's premium, net APTC, is [\$\$\$] for 1/1/16-5/1/16 and [\$\$\$] for 6/1/16 to the present. The consumer was advised by Marketplace that their APTC had changed, resulting in a premium difference that is greater than expected. The consumer was also advised how income changes, failure to reconcile their taxes annually, and/or failure to clear an income data match issue, can impact their APTC. The consumer understood and appreciated the information. The consumer was advised to contact the Marketplace to seek advice on any appeal recourse they may have, since retroactive APTC cannot be awarded by the issuer. A resolution letter will be mailed to the subscriber on [Date].

Escalations

HICS : Health Insurance Caseworker System

Effective date changes

Effective date changes can be related to special enrollment periods, Marketplace or issuer errors, and cancellations or terminations.

Example: During OEP, an enrollee reports to the Marketplace that they were assigned a February 1 effective date rather than a January 1 effective date because they indicated that the previous plan ended coverage January 1 rather than December 31. The Marketplace Call Center representative opens a HICS case to move the effective date to January 1.

The issuer has made the effective date change as directed or permitted to do so by CMS. Confirmed consumer is a member and that contact information in the HICS case and on file is a match. Issuer thoroughly reviewed enrollment files and records.

HICS Summary after Issuer investigation

Enrollment 834 file received on [Date] and binder was paid on [Date]. Enrollment was effectuated on [Date] and has been adjusted to [Date] per HICS direction. The consumer has been advised of addition premium amounts that are owed. The consumer was informed that they will receive a confirmation letter in the mail regarding the effective date change and resolution. Consumer was satisfied and had no other issues to report.

Escalations

HICS : Health Insurance Caseworker System

Dental Plan Terminations

Consumers can end their Marketplace dental coverage without also terminating their Marketplace health plans by calling the Marketplace Call Center or by contacting their dental issuer directly.

HICS Summary after Issuer investigation

The consumer's request to terminate their Stand Alone Dental Plan with [Plan Name] has been honored with an effective date of [Date]. Any balance on the consumer's account will be sent to the consumer within 10 business days. Mailed resolution letter to consumer. HICS case is resolved.

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HICS: Health Insurance Caseworker System

Suspected Fraud is not a HICS escalation but should be reported to the FFM.

As with any online activity, consumers have the potential to run into Marketplace scams and fraud, such as untrusted sources asking for the consumers' personal identifiable information.

When to report suspected fraud

It's time to take action if:

- Someone other than the insurance company you've chosen contacts you about health insurance and asks you to pay – or asks for your financial or personal health information
- Someone you don't know contacts you about getting health insurance and asks you to pay – or asks you for your personal financial or health information
- Someone contacts you and claims to be from the government or Medicare – and asks you to pay for a new "Obamacare" insurance card
- Someone asks you to give your personal health, bank account, or credit card information to someone who calls you and says they're from the government

How to report suspected fraud

You can report suspected fraud one of 2 ways:

- If you suspect identity theft, or feel like you gave your personal information to someone you shouldn't have, use the [Federal Trade Commission's online Complaint Assistant](#). You should also contact your local police department. [Visit www.ftc.gov/idtheft](http://www.ftc.gov/idtheft) to learn more about identity theft.
- Call the Health Insurance Marketplace call center at 1-800-318-2596 (TTY: 1-855-889-4325). Explain what happened and your information will be handled appropriately.



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Summary

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Summary

Determine if the reason for a complaint or issue is due to policy and can be explained and does not require additional help.

Know where to report the issue.

Encourage QHP consumers to attempt to resolve with their issuer.

Report QHP issues to the HealthCare.gov call center at 1-800-318-2596.

Suspected Fraud is not a HICS escalation but should be reported to the FFM.



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